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ABSTRACT

The notions of both work and persistence carry implicit assumptions that some obstacles have to be overcome through effort. Given the hurdles that women physicians must overcome in training, most research has assumed that work plays an important role in their lives. A sample of 71 women physicians from an earlier study was surveyed to learn why some women invested more heavily in their careers than others. Results showed that adversity, either status or emotional, proved to be a compelling reason for career persistence. The earlier women imagined being physicians, the more likely they were to persist in their careers. Persisters developed stronger masculine personality components and more distant or equivalent relationships with their parents. Women who were less close to their fathers did not develop as strong feminine personality components and were less likely to commit themselves to traditional role relationships. The findings indicate that nearly all the subjects freely pattern their lives in harmony with their inner beings.
(JAC)

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Why Women Want to Work: A Look at Career Persistence*

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Why Women Want to Work: A Look at Career Persistence

The U.S. Department of Labor (1981) indicated that 52.3 percent of women aged 16 years and older were working outside the home by the third quarter of 1981. This is an increase of more than 1.1 million female workers since the third quarter of 1980. The reasons for choosing to work vary from the compelling needs to support oneself and others, to the need to help a spouse to make ends meet during difficult economic times, to feeling a sense of obligation to fulfill oneself as part of a new social revolutionary tide among women, to satisfying some private, inner need. Explanations for the current increase in female labor force participation range from the first-mentioned, external implications, to the less obvious final suggestion. I have been interested for some time in the latter psychological reasons behind the work motive in women. Specifically, I have been studying a sample of licensed women physicians in order to learn why some invest more heavily in their careers than others, as indicated by their degree of career persistence. The main purpose of the research has been to develop a theory of feminine career persistence which, along with a full report of the research, may be found in Work, marriage, and motherhood: The career persistence of female physicians, published by Praeger in 1981. I would like to share what I have learned, in a general way, with you today.

Theory

The notions of both work and persistence carry implicit assumptions that some obstacles have to be overcome through effort. The obstacles

that women who find work salient in their lives exist both externally and internally to the self. Women physicians, since the establishment of the AMA more than a century ago by all-male allopaths, have tasted exclusion and discrimination (e.g., Campbell, 1973; Walsh, 1977). Despite the fact that women characteristically nurture the sick, women have been viewed as alien to the profession both by physicians and by society. As recently as the early 1960's, female undergraduates who contemplated medical careers (Rosenberg, 1968) commonly did not apply to medical schools because they recognized the difficulties that they might have in trying to manage careers along with the traditional roles of marriage and motherhood, and because they sensed the hostility of the profession and society as a whole toward women who dared to enter this powerful guild.

How, then, may we understand the behaviors, first, of women who challenged these perceptions, and second, those who entered medicine and chose to work more continuously than their women colleagues? We may assume, given the many hurdles that they overcome in training, that all women physicians find work salient in their lives. We are examining a subset within the larger population of career-committed women. The equilibrium point of social attitudes toward women has moved in the direction of quality and liberalism during the recent decade. I very much hope that these sometimes fragile and tenuous inroads solidify. However, until these changes resist pressures over time, and for example, female medical school enrollments continue to increase, then we may be experiencing only a more superficial societal and subsequent personal

shift in attitude that has not yet seeped into the core of our social being.

Three possible answers emerge. First, there may be women who develop independent of the traditional dominant expectations for sex-appropriate behavior. Second, there may be women who perceive society's older message, but who feel compelled to overcome the obstacles imposed by the larger society, the medical profession, and even those close to them for reasons that stem from within. Three, some women may integrate both the traditional expectations that one marry and mother, along with the wish to establish a career outside the home equivalently. Let us see how these may develop.

The real pull toward what the Freudians describe as the "feminine core" of traditional marriage and motherhood occurs during adolescence (e.g., Deutsch, 1944; Matthews & Tiedeman, 1964). Therefore, if someone imagines a daring, nontraditional career, such as medicine, prior to the onset of adolescence she may be more resistant to the pressures to conform to the dominant societal norm for traditional behavior when adolescence arrives. The goal may become part of her personality at an early stage of development and remain central to it during subsequent differentiations and integrations.

The second explanation, the willingness to overcome obstacles, may have its origins during the early years as well. Anne Roe (1964) suggested that unfulfilled needs may become unconscious motivators in later life. I imagined that early disadvantage, either socioeconomic or emotional, might account for the determination of the persister.

Women who were relatively poor as children, or who came from families of limited educational background, or who were the offspring of immigrants, might well wish to forge ahead into the mainstream of American life. Furthermore, women who, as children, were either poorly loved, or who experienced unhappy home lives because of marital discord or early parental death, might similarly choose to invest in their career in later life as a way of avoiding similar pain again. Parents may want to satisfy their own unconscious needs through their children (e.g., Shaver, French, & Cobb, 1970). Some women may enter medicine unwittingly in order to fulfill their parents' ambitions.

The life of women physicians is rife with obstacles. They must pay very large sums for their educations and meet educational tests of merit through licensing and board examinations. They need to confront the norm ambiguity experienced by women physicians: marginal individuals who as women and as physicians are vulnerable to a variety of inner tensions that stem from their needs to cope with a predominantly male profession and a society that still has not seen fit to pass legislation equating the rights of men and women. One means to cope with this strain is to pursue one's career with a singularity of purpose, minimizing inner stress and focusing upon the career, much as the middle-level managers of Hennig and Jardim's (1977) study have done. The persisting woman physician may deal with her own inner difficulty by fastening more strongly upon the goal. She may resolve the issue of marginality by closing off as best she is able the traditional role options of marriage and maternity. The nonpersisting physician may

invite inner unrest because she is less likely to choose between groups and roles. Since she does not establish clear career role dominance, the nonpersister may be more vulnerable to the strains induced by marginality.

For those women physicians who do choose to juggle both professional and traditional roles, the opportunities for conflict may increase. Why should a woman want to marry, mother, and practice medicine?

Most physicians do marry, and tend to compromise in their careers in order to manage multiple roles (Mandelbaum, 1978). Those who have children characteristically withdraw for a time; however, both the frequency and durations of withdrawals have decreased in recent years (Mandelbaum, 1978). Those who prefer may choose the more extreme options of withdrawal, either from the traditional roles, or from their careers. The reasons which underlie these decisions reflect the values and priorities of the individual.

Although successful management eases the relationship between spouses, the quality of the relationship is built upon more psychologically central issues. Of particular concern is how a husband feels about his wife's career. A generation ago, 400 Radcliffe PhD alumnae succeeded in neither their careers nor their marriages without the support and the approval of their husbands (Cronkhite, 1956). More recently, 75 percent of the entering male freshmen at Princeton still believed that women belong in the home (Sherman & Jones, 1976). It is little wonder, therefore, that achieving women may fear rejection by

men the most important source of support or hostility (Bailey, 1974). Quite possibly, women who invest heavily in their careers feel that their husbands are supportive of them; whereas those who withdraw from their careers sense their husbands' dissatisfaction.

The result of these perceptions still rest within the woman herself. Most women tend to rely upon others in difficult times (Hoffman, 1972). Those who entered nontraditional fields in at least one study (Trigg & Perlman, 1976), had lower needs to affiliate than the average woman. Perhaps women who work more continuously do so because they are freer of the need to affiliate, to rely upon the approval of others, and function more autonomously. Furthermore, the economically secure woman physician is capable of ending a fruitless marriage.

Similarly, child-related management issues are perhaps more acceptable talking points than the more basic issues that affect ultimate decisions to withdraw from work. Appropriate substitute care is often difficult to find, and may account for a mother's withdrawal. I suspect, however, that a more basic reason for withdrawal is that intelligent, sensitive women, familiar with Freudian theory, are deeply concerned about the well-being of their children. There will always be women who simply want to be at home with their children while they are young. And at 180 degrees away, there will always be women who prefer not to either bear children or to rear them. These deep-rooted feelings, and all that lie in between, affect critically a woman's ultimate decisions about the role of work in her life.

Inner conflict about self-definition varies among women physicians.

Whether we choose to attribute inner strain to marginality or to multiple role conflict is of little matter. The root cause remains how a woman feels about her responsibilities to herself, her work, her husband, and her children, and its effect upon her work behaviors.

Less conflicted women may be freer of the more traditional attitudes toward sex-appropriate attitudes and behaviors. These women may tend not to worry during adolescence about the "appropriateness" of their career behaviors. They may be more certain of their control over their destinies, and unhesitating about displays of task-related competence. Women who freely pursue their career goals deviate from the norm and they may be expected to show personality profiles that vary from the traditionally feminine profile rich with negative male attributes. We may expect to find the most career-committed persister less anxious and dependent than the more traditional nonpersister. If most women fear that society discourages the achievement of women (Tangri, 1975), we may expect to find persisters even more achievement-oriented than nonpersisters. Women who behave most like males in their careers may be able to work as they do because their personalities reflect removal from what is considered traditionally feminine. Therefore, if women are reared to be independent of societal constraint, they will evidence their difference in measured personalities. Our next question, then, is to try to explain how these differences in personality develop.

The more traditional behavior of the woman who withdraws for family reasons may result, in part, from a close father-daughter relationship. The class of behaviors in which we are now interested is the

more traditional within a sample of nontraditional women.

Earlier evidence suggest that paternal identification results in nontraditional work choice (e.g., Hennig & Jardim, 1977; Helson, 1972; Roe & Siegelman, 1964). Cross-sex parental relationships induce empathic, nontraditional role behaviors in daughters.

However, fathers also develop femininity in their daughters (e.g., Mussen & Rutherford, 1963; Heilbrun, 1965). According to psychoanalytic thinking, fathers curb the outward activity of their prepubertal daughters by admonishing tomboys and redirecting the energies of their daughters inward toward the cultivation of the inner life (Deutsch, 1944). Poor father-daughter relationships account for deterred development of the feminine part of the self (e.g., Bronfenbrenner, 1967; Sears, Pintler, & Sears, 1967; Sopchak, 1952).

We may expect to find nonpersisting women physicians closer in identification to their fathers than the persisters. This paternal closeness may account for their developments of both strong masculine and feminine personality attributes. The lack of paternal closeness may produce less traditionally feminine personality attributes and adult role behaviors among persisters.

Except for unusual instances of discrimination or the unavailability of either work or household help, this scheme rests heavily upon the influence of the early years of development. The career woman is a person, a woman, as well as a worker. The relative value of work in the life of a woman reflects her early years of development, and her subsequent personality.

Testing the Theory

With these ideas in mind, I selected the names at random of 100 licensed women physicians in the Philadelphia metropolitan area out of a total population of 558, 71 of whom participated in the 1973-74 study. Each participant completed a mailed questionnaire which provided basic demographic information about which in-depth, structured interviews were designed. At the conclusion of each interview, with one exception, the Adjective Check List (Gough & Heilbrun, 196), a personality inventory, was administered.

The samples of 40 persisters and 31 nonpersisters were drawn by using the median number of cumulative nonwork years as a criterion. A basic correlation design was used to test nearly 100 hypotheses derived from the theory.

Five years later the theory was retested because of the correlational nature of the original study. Fifty-seven of the then 65 living original subjects, which included 30 persisters and 27 nonpersisters, responded to mailed questionnaires and the ACL. Two target samples, believed to behave similar to persisters, were compared with comparison groups. Seven women who returned to active practice by 1978-79, but who had been inactive 5 years earlier, were compared with six women who remained inactive. Retirees for reasons of ill health or age were excluded. Six women who moved away from marriage during the 5 year interim, either through divorce or separation, were compared with 30 women who remained married. I assumed that women who either returned to active practice, or who moved away from marriage, should have

developed in persister-like fashion. I would like to share next with you some of the major conclusions of the research.

Conclusions

The conceptual framework upon which the study was based accepted the basic notion that instrumental work behaviors develop from the earliest years and express the self. Since women in our society tend not to invest heavily in careers, I assumed that women physicians who interrupted their careers would more closely approximate the psychological developments of the average woman. Second, I assumed that adversity would account for career-salient behaviors.

Adversity

Adversity proved a compelling reason for career persistence. This adversity may take either of two forms: status or emotional.

Women whose parents suffered economic, political, or racial distress never again wanted to taste the bitterness of their parents' lives. Their climb toward medical licensing was usually sprinkled with obstacles unknown to women of advantaged circumstances: unfamiliarity with "the system," financial difficulties, and a lack of support. Persisters looked back not only upon worlds they chose to leave, but on the painful course that they had successfully overcome. Medical careers were cherished, hard-won prizes not to be relinquished.

Psychic trauma may also catapult women into careers. Half the single persisters experienced psychological pain during childhood that was sufficiently scarring that they chose not to marry. Marriage

sometimes brought either economic or psychic pain later and similarly caused women to strengthen their career commitments.

Relative status disadvantage breeds career persistence; relative advantage does not. Women born to parents of higher social status had fewer external obstacles before them and overcame less psychological and status distance in becoming physicians. In the most extreme instances of nonpersistence, a half dozen women of very advantaged families married men from similar backgrounds and led traditional lives. They lacked the incentives bred by adversity.

Early Goal Imbedding

The earlier women imagined becoming physicians, the more likely they were to persist in their careers. Persisters, returnees, and separated/divorced women all first thought to become physicians at earlier ages than their comparison groups. This enabled them to resist pressures to conform to traditional images during and after adolescence.

Differences in developments of the feminine core also account for career behaviors. Persisters developed stronger masculine personality components than nonpersisters; the latter developed equivalently strong masculine and feminine components. Nonpersister development traced back to paternal identification; persisters more commonly developed equivalent, and sometimes distant, relationships with their parents. Longitudinal study confounded the issue somewhat. The returnees identified with their fathers, and the long-term inactives encountered equivalent, distant parental ties. The long-term inactives enjoyed privileged

social status while sometimes lacking parental warmth. Therefore, their need for affection exceeded their career needs, and explained their devotion to their husbands and children.

Quite clearly those who developed both strong masculine and feminine personality components were more likely to marry and to mother, making the continuous practice of medicine more difficult. Women less close to their fathers did not develop as strong feminine personality components and were less likely to commit themselves to traditional role relationships.

By the close of adolescence, two early traces converged. Persisters, who, as a group, had not been particularly close to their fathers satisfied their driving needs for economic independence through their careers. In contrast, the paternally identified nonpersisters, who developed strong masculine and feminine personality components, in the absence of low family social status, moved toward adulthood and the mutual fulfillments of instrumental and traditionally feminine roles.

The 71 women physicians chose boldly as individuals. By their very choice of profession they marked themselves as exceptional. Despite occasional career interruptions nearly all developed rich professional lives filled with good work. Those who chose to remain out of medicine for extended periods of time showed courage by daring to divorce themselves from lifelong career commitments. This small handful of women found satisfaction for their strongest needs through their husbands and children. The women who returned to active practice had struggled to become physicians. They left when their instincts drew

them to the needs of their children; and they fought to return to active practice when they felt able. The women who preferred neither to marry nor to have children challenged societal expectations and remained true to their inner selves. Nearly all 71 women physicians freely patterned their lives in harmony with their inner beings.

It is time for women to mold their own destinies according to their wishes and needs as individuals. To do so requires self-understanding, honesty, and courage.

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